

# FORM #11

## DENTAL EXPENSE CLAIM

### for LEOFF-I POLICE AND FIRERFIGHTERS

To request approval of reimbursement of dental expense incurred, or to seek pre-approval of future treatment, complete Form #11. Attach the invoice for services completed or a quote of work planned in the future. If you carry dental insurance, your invoice must be submitted to that insurance first. **Only amounts not covered by insurance can be claimed.** Submit all paperwork to your LEOFF-I employer for direct reimbursement. If necessary, your LEOFF-I employer may choose to forward your claim to the Disability Board for final approval.

PATIENT'S NAME: \_\_\_\_\_ Case #: \_\_\_\_\_

DENTIST'S NAME: \_\_\_\_\_

DENTIST'S PHONE: \_\_\_\_\_ Tax ID: \_\_\_\_\_

DENTIST'S ADDRESS: \_\_\_\_\_

Service Date	ADA Code	Description	Amount
<b>TOTAL CLAIMED:</b>			

I hereby attest that dental services rendered were solely for non-cosmetic reasons.

\_\_\_\_\_  
LEOFF-I Member/Patient Date

\_\_\_\_\_  
Dentist Date